SF 4400-TOP (2-2000) Supersedes (6-99) issue

Sandia National Laboratories

INSTRUCTIONS FOR FILING CLAIM

1. Insured completes this side of form for medical claims.
2. Attach itemized bills or have attending physician complete the reverse side
3. Send the completed form and bills to the address given.

SEE REVERSE SIDE FOR ADDRESS TO MAIL CLAIMS

Please circle your plan no. below.

Top-PPO/Out of Area Plan
Administrator: United of Omaha Life Insurance Company
Group Plan No. GUSI-20L1

Top-Pos Plan – Security Police Association (SPA)
Administrator: United of Omaha Life Insurance Company
Group Plan No. EN-20K8

To be completed by Primary Member

1 ☐Male ☐Female

Please Print Last Name First Middle

Home Address

City, State, ZIP Code Home Phone Number

Date of Birth - - Social Security No.

2 Yes ☐ No ☐ Is this illness or injury work related?

Yes ☐ No ☐ Was this an injury due to an accident? If so, please give details. (For possible third-party liability)

Date of Accident Where Did Accident Occur?

Describe the accident fully:

I authorize payment of benefits to the physician or supplier.

Insured's Signature Date

4 Yes ☐ No ☐ Is this a dependent claim? If so, please fill out this box.

☐Male ☐Female

Full Name of Dependent

4a Date of Birth Relationship to Employee

☐Class I ☐Class II

5 Yes ☐ No ☐ Are you married?

Yes ☐ No ☐ Is your spouse employed? If so, you must fill out this box

5a Spouse's Birth Date Spouse's Social Security No.

Name of Spouse's Employer

Address of Spouse's Employer

6 Yes ☐ No ☐ Are you or your dependent insured under any other group medical expense plan, Medicare or CHAMPUS? If so, please fill out this box.

Other Policy No. Name of Other Insurance Company or Plan

Address of Other Insurance Company's Claims Settlement Office

Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

AUTHORIZATION FOR RELEASE OF INFORMATION (Signatures Are Required)

I authorize any physician, medical practitioner, hospital, Veterans Administration hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency, employer or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other nonmedical information of me or my minor children to give to United of Omaha Life Insurance Company (hereinafter called United of Omaha) or its legal representative, any and all such information.

I understand the information obtained by use of the Authorization will be used by United of Omaha to determine eligibility for benefits or services under a plan of benefits. Any information obtained will not be released by United of Omaha to any person or organization, EXCEPT to reinsuring companies, employer group policy holder, contract holder, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request to receive a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for two and one-half years from the date shown below.

I hereby certify the statements hereon and attached are complete and accurate, and I agree that my Sandia Plan will be subrogated to or reimbursed from any recovery I or my dependent may have against a third party to the extent of benefits provided.

Date Employee's Signature Patient's Signature (if other than a minor child)

ATTENDING PHYSICIAL STATEMENT

Do not complete this section if you are attaching itemized bills that contain all the needed information.

PHYSICIAN OR SUPPLIER INFORMATION

1. DATE OF	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	2. DATE YOU WERE FIRST CONSULTED FOR THIS CONDITION	3. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO
4. DATE PATIENT ABLE TO RETURN TO WORK	5. DATES OF TOTAL DISABILITY FROM THROUGH		DATES OF PARTIAL DISABILITY FROM THROUGH
6. NAME OF REFERRING PHYSICIAN			7. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
8. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED *(if other than home or office)*			9. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ YES ☐ NO CHARGES:

10. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, OR DX CODE

1.

2.

11. A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE	*(Explain unusual services or circumstances)*	D DIAGNOSIS CODE	E CHARGES	F AMOUNT PAID	F BALANCE DUE

12. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED DATE		13. TOTAL CHG	14. TOTAL AMT PD	15. TOTAL BAL DUE
	16. YOUR SOCIAL SECURITY NO.	17. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND *TELEPHONE NO.*		
18. YOUR PATIENT'S NAME AND ACCOUNT NO.	19. YOUR EMPLOYER 1.D. NO.	I.D. NO.		

*PLACE OF SERVICE CODES

1 - (IH)	- INPATIENT HOSPITAL	4 - (H)	- PATIENT'S HOME	7 - (NH)	- NURSING HOME	O - (OL)	- OTHER LOCATIONS
2 -,(OH)	- OUTPATIENT HOSPITAL	5 -	- DAY CARE FACILITY (PSY)	8 - (SNF)	- SKILLED NURSING FACILITY	A - (IL)	- INDEPENDENT LABORATORY
3 - (O)	- DOCTOR'S OFFICE	6 -	- NIGHT CARE FACILITY (PSY)	9 -	- AMBULANCE	B -	- OTHER MEDICAL/ SURGICAL FACILITY

Top-PPO – Two Option Plan/Out of Area Plan
Top-Pos Plan – Security Police Association (SPA)

Mail Medical Claims to:
United of Omaha
3200 Oklahoma Ave.,
P.O. Box 9
Woodward, Oklahoma 73801
Phone 1-800-488-0167 Customer Services